



HEALTH INSURANCE PREMIUM PAYMENT PROGRAM APPLICATION

POLICY HOLDER NAME	ADDRESS		SOCIAL SECURITY NUMBER

1. Complete the following information regarding the insurance policy.

INSURANCE CARRIER'S NAME	ADDRESS	TELEPHONE NUMBER

2. List all persons eligible for coverage under this policy.

NAME	DATE OF BIRTH	MEDICAID ELIGIBLE	PIC CODE

	YES	NO
3. Are you currently enrolled in this policy?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are your dependents currently enrolled?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you a Medicare recipient?	<input type="checkbox"/>	<input type="checkbox"/>

6. How much are the premiums?	7. How much are your copays?	8. How often are premiums paid?
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9. Is this policy through an employer? YES <input type="checkbox"/> NO <input type="checkbox"/>	If yes, list employer's name and telephone number (including area code)
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10. Check the services covered under the policy.

<input type="checkbox"/> Hospital	<input type="checkbox"/> Dental	<input type="checkbox"/> Lab/Xray	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Physician	<input type="checkbox"/> Drug	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Medical Equipment

SIGNATURE	DATE
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INSTRUCTIONS FOR COMPLETING THE APPLICATION

If you want COB to consider paying your health insurance premiums, please complete the application on the opposite page. Detach the completed form and fold the form in half at the dotted line so the address shows on the outside. Be sure to moisten the adhesive strip at the bottom of the application to seal the form. **No postage is necessary.**

Enter the policyholder's name, address, social security number and telephone number in the spaces provided. If you do not have a telephone, list a number where you can be reached or a message left:

- Question 1. List the name, address and telephone number of the insurance company, the name of the policy holder and policy number in the spaces provided.
- Question 2. List the name and birth date of everyone in your family who is eligible for coverage under this policy. Indicate whether the person is currently receiving Medicaid and, if yes, list the person's state Patient Identification Code (PIC).
- Question 3. Indicate whether you currently have coverage under this policy.
- Question 4. Indicate whether your spouse or children currently have coverage under this policy.
- Question 5. If you receive Medicare, check "Yes".
- Question 6. List how much the insurance premiums cost each time a payment is due.
- Question 7. If the insurance is through an employer and the employer pays for part of the cost, **list only your share of the cost.**
- Question 8. List how often a premium is due. For example, biweekly (every two weeks), monthly (once a month), bimonthly (every two months), quarterly (Every three months), annually (once a year), and so forth.
- Question 9. If this policy is through an employer, check "yes" and list the name and telephone number of the employer.
- Question 10. Check all of the services covered under this policy.
- Signature Sign and date the application form at the bottom.

QUESTIONS?

Call the Coordination of Benefits Toll-Free Number

1-800-562-6136

If your last name begins with letters:

**A-F - contact Michele ext. 5-1181, or
E-mail - hergent@dshs.wa.gov**

**G-N - contact Denise ext. 5-1199 or
E-mail - barkedm@dshs.wa.gov**

**O-Z - contact Jeri ext. 5-1046 or
E-mail - milliejl@dshs.wa.gov**